TOPICS IN PATIENT SAFETY®

VOL. 12, ISSUE 6
November/
December 2012

Contents

Pages 1 and 4:
Broadening the Impact of The Daily Plan®

Page 2:
Improving Transitions for Mental Health Patients

Page 3:
Using the Patient Safety Assessment Tool (PSAT) to Conduct a Prospective Risk Analysis

VA National Center for Patient Safety
P.O. Box 486
Ann Arbor, MI 48106-0486

Phone: .....(734) 930-5890
Fax:.....(734) 930-5877
E-mail: ..... NCPS@va.gov

Web Sites:
Internet .....www.patientsafety.gov

Robin R. Hemphill, M.D., M.P.H.
VHA Chief Safety and Risk Awareness Officer

Director, VA National Center for Patient Safety

Joe Murphy, M.S., APR
Public Affairs Officer
Editor

Deborah Royal, VHA-CM
Visual Information Specialist
Graphic Design and Copy Editing

TIPS is published bimonthly by the VA National Center for Patient Safety. As the official patient safety newsletter of the Department of Veterans Affairs, it is meant to be a source of patient safety information for all VA employees. Opinions of contributors are not necessarily those of the VA. Suggestions and articles are always welcome.

Thanks to all contributors and those NCPS program managers and analysts who offered their time and effort to review and comment on these TIPS articles prior to publication.

TiPS®

NCPS VA National Center for Patient Safety

Broadening the Impact of The Daily Plan®

By Cheryl A. Mitchell, R.N, B.S.N., M.S.A., NCPS nurse coordinator, and Beth J. King, R.N., B.S.N., M.A., C.C.M., NCPS program manager

The Daily Plan® is an important initiative that enhances patient safety and patient empowerment. Although not a new concept, this article provides not only background information about the plan, but updates as to how facilities have spread the implementation to ambulatory care areas and the outcomes they have achieved.

Introduction

In 2007, NCPS collaborated with the Office of Nursing Service to launch Phase I of The Daily Plan® at five VA medical centers on medical/surgical units.

The program was initiated as a patient safety and quality tool that "empowers" patients and families to "speak up" and become involved in the Veteran's plan of care.

The plan is a patient-specific document reviewed with patients each day of their hospital stay. It's based on a simple principle: When a patient knows what to expect each day, he or she may be able to identify an unplanned or unexpected event.

The plan includes items such as allergies, medications, scheduled procedures, clinic appointments, and diet.

The goals

- Provide patient centered care with a patient-specific document that lists what to expect during each day in the hospital
- Enhance patient safety by encouraging the patient to ask questions if something seems different than planned
- Strengthen the communication process and establish a shared mental model between patients, providers and caregivers
- Help meet the Joint Commission National Patient Safety Goal, "Encourage patients' active involvement in their own care as a patient safety strategy"
- Make the process efficient by drawing upon information already in the electronic medical record

Benefits

- Encourages patients to speak up and be involved in their care
- Helps prevent possible adverse events
- Improves the patient safety culture
- Enhances continuity of care
- Strengthens the connection between the patient and those involved in his or her care
- Provides an opportunity for patient education and identification of patient education needs
- Establishes a plan to help guide/progress the care
- Facilitates and augments the discharge planning process

A snapshot of The Daily Plan®

The Daily Plan® is actually in a "health summary" format that is created by selecting a list of components specific to the unit or ambulatory area.

It pulls active orders directly from the VA's Computerized Patient Record System for those selected components and prints them into a health summary format, which is called The Daily Plan®. There is *no software* required to implement.

Patient satisfaction continues to support use of the plan

The Phase II pilot, initiated in 2009, included additional types of inpatient units, to include nursing units such as mental health, community living center, spinal cord injury unit, and intensive care unit/telemetry.

Phase II data indicated that 77 percent of patients agreed or strongly agreed that the plan increased their understanding of their hospital stay and made it easier for them to ask their nurses and doctors questions; furthermore, 86 percent of patients in Phase II agreed or strongly agreed that the plan helped them feel more comfortable with their hospital stay.

Continued on page 4

Improving Transitions for Mental Health Patients

By Joe Murphy, APR, NCPS public affairs officer

Using process improvement, the Emergency Department (ED) and Psychiatric Emergency Services (PES) staff at the VA Puget Sound Health Care System have developed a tracking tool to facilitate patient-centered care and reduce communication breakdowns.

In June 2011, ED and PES staff members completed Medical Team Training (MTT),[1] a program developed by NCPS to improve patient care outcomes through more effective communication and teamwork among providers.

"While MTT had never been used for this type of clinical group, it seemed to me that there were communication and collaboration-type issues that MTT could help us with," said Christopher Bundy, M.D., M.P.H., director of Puget Sound's Acute Care Mental Health Services. "The way we engaged with one another professionally was unsatisfactory."

Members of both teams felt their ability to offer the highest quality, patient-centered care was being compromised by communication breakdowns and tension between the groups.

Dr. Bundy approached the ED leadership saying: "MTT is coming to help with other departments. Would you be willing to get involved? And the answer was yes."

The ED and PES teams completed MTT together. During training, they identified that the communication breakdowns and frustrations stemmed from a common cause: a lack of clarity of roles and responsibilities.

"It was pretty clear, based on our hospital policy, that patients needing psychiatric care were first and foremost ED patients, that the psychiatric emergency service's role was consultative. That's not what was happening," said Dr. Bundy.

PES roles and responsibilities were not always consistent between shifts, blurring whether staff members were to play either a primary or consultant role.

"This set up different expectations between the ED staff and the psychiatry residents about their roles and led to chronic conflict," he said.

During MTT, the team decided to implement interdisciplinary briefings, a key aspect of MTT. The briefings were scheduled at two-week intervals over the following year.

"The idea was to get all the players involved," said Dr. Bundy, "from the time the patient came in the door with psychiatric problems to the time a patient was discharged or admitted."

The initial goals were:

- Open communication
- Common understanding of roles and responsibilities
- Identification of breakdowns in communication and care processes
- The development and implementation of strategies to address identified problems

Most importantly, the interdisciplinary team's objective was to develop a systems-based solution that would allow individuals to put their emotions and frustrations with the previous system behind them.

"The solution was the development of a tracking sheet for the ED that helped identify that a specific patient needed to get a PES assessment, but contained a standard list of other things," said Dr. Bundy.

The bright green tracking sheet remains with a patient through triage, consultation and discharge or transfer.

"When a staff member from psychiatric services picks up the patient, that caregiver can see that all initial ED services have been done," he noted.

The sheet also helps standardize encounters. "If a patient does not need further care that day, follow-up appointments are scheduled and the psychiatric services staff member returns the patient to the ED triage nurse, closing the loop to complete the ED course of care, both clinically and administratively," Dr. Bundy continued. "As importantly, it helped ED staff develop a sense of ownership around patients with primary psychiatric problems. This new system puts everyone on the same page, literally, and eliminates the confusing communications and uncertainty about professional roles that were occurring."

But to ensure the new system was accepted, the team learned it had to change the terms of the discussion.

"We learned early on to avoid the terminology 'culture change.' We found that it was really offensive to people because it implied that staff members didn't display *esprit de corps* or camaraderie," he said. "It was like we were coming in and undermining how front-line staff pictured themselves."

The team adopted a term they considered less pejorative, less value-laden. "We focused on 'process change.' People could rally around that and say, 'Okay, there are some things we could do with the process to make it better.' It worked," Dr. Bundy said.

To further encourage front-line staff involvement, the team didn't hand down a finished product. "We said we are going to pilot this and adapt and modify it to best suit people on the front lines," he noted. "This led to a lot of collaboration and made everyone feel they were part of the effort."

The relationship between ED and psychiatric services has vastly improved. "We are all pulling the oars in the same direction now," Dr. Bundy concluded, "and the patient, not our differences, is squarely in focus."

Reference

1. For information on this and other NCPS programs and initiatives, visit *www.patientsafety.gov*

Using the Patient Safety Assessment Tool (PSAT) to Conduct a Prospective Risk Analysis

By Elizabeth A. Mattox, M.S.,M.S.N., A.R.N.P., C.P.P.S., patient safety manager, and Carol Lukasewicz, R.N,B.S.N., VA Puget Sound Health Care System; and Joe Murphy, APR, NCPS public affairs officer

During the construction and activation of the American Lake Community Living Center (CLC) at the VA Puget Sound Health Care System, members of the patient safety program conducted regular on-site reviews as part of an interdisciplinary team.

Potential risks in this new environment of care were identified using PSAT,[1,2] a tool developed by NCPS. The team included representatives from facilities, safe patient handling, safety, quality improvement, long-term care clinical staff, and interior design.

Once vulnerabilities were identified, NCPS' Healthcare Failure Mode Effect Analysis (HFMEA)[1] concepts were applied. A criticality score was calculated for each finding based on severity and probability of harm.

Action items and outcome measures were developed for all high-criticality failure modes.

The use of this scoring process allowed the organization to focus on the highest risk hazards. For critical areas of concern, stakeholders participated in corrective action plan development.

Over a period of months, from late construction to building occupancy, reviews were completed and the tool we developed was revised. The result was an instrument that facilitated objective evaluation of both the physical environment and care processes.

Specific areas of focus of the PSAT tool included elopement, fall prevention, safe patient handling, National Patient Safety Goal compliance, and fire safety.

In some cases, potential concerns were monitored over time as the risk could not be quantified. For example, some team members were concerned that a threshold in the dining area posed a trip hazard, even though it conformed to design standards.

Redesign was considered quite costly and there was no clear justification for it. After monitoring the area for several months following activation, the team concluded there was no increased trip or fall risk and the original design remains in place.

By using PSAT/HFMEA as the basis for the prospective risk analysis, the team was able to translate subjective concerns into objective findings with a criticality level, an action item, and an outcome measure.

The clinicians and the project design team often had different perspectives about the necessity of making changes. For example, the clinical team requested to install departure alert systems on all four of the CLC units; the original plans called for installation on only two units.

PSAT, however, specifically addresses the risk of elopement. By combining PSAT, core principles of patient safety (e.g., standardization of units), and "Long-Term Care Cultural Transformation" (e.g., allowing patients to remain in their "home" unit regardless of progressive cognitive decline), the interdisciplinary team successfully justified the placement of departure alert systems in all four of the new units prior to activation.

While installation of departure alert systems on all units was costly, the criticality score demonstrated the importance of completing this modification *prior* to occupancy.

One of the reasons for the success of the project was use of a hands-on, collaborative approach to identifying hazards and to problem solving.

For example, the safe patient handling coordinator demonstrated the lift system in a communal bathroom, using another team member as the "patient." It was immediately apparent to the "patient" that additional privacy curtains would be needed.

In another room, the toilet paper dispenser was out of reach, resulting in a fall risk.

Overall, 62 findings were identified prospectively. Approximately 75 percent of these were deemed high-criticality in nature. Corrective action plans were developed for these findings. A total of 51 actions and recommendations were made.

Using PSAT as a prospective risk analysis model − and focusing the team's efforts through the use of HFMEA scoring – allowed concise and evidence-based recommendations prior to activation.

It is particularly rewarding to use established tools, such as PSAT and HFMEA, for new applications.

We have applied the same concept to other key activations, such as a new emergency room, the domiciliary, and the psychiatric emergency services unit.

In each case, teams proactively identified risks which were corrected, reducing the risk of harm to Veterans.

The bottom line? The ability to *quantify* risks prior to the activation of a new environment of care results in the proactive correction of hazards, improves patient and staff safety and satisfaction, and is fiscally responsible.

References

1. For information on this and other NCPS programs and initiatives, visit *www.patientsafety.gov*
2. PSAT is available to authorized users on the NCPS Intranet site; however, a sample version in Microsoft Excel is available to the public and can be down-loaded from the NCPS Internet site: *http://www.patientsafety.gov/SafetyTopics.html#mheocc*

Broadening the Impact of The Daily Plan®

Continued from page 1

Because of the plan, these patients noted that they had a clear idea of what to expect each day – and that it provided them with information that helped improve their care.

Comments from patients and their family members have included:

- The more informed I am the higher my comfort level
- Helps you to get your thoughts together
- It made me well aware of what was going on with my care
- It was helpful to identify medications, appointments and contact information
- Very helpful to me so I know about my husband's care so that I can help take care of him
- I have something to take home and look over with my family about the care I am receiving

These and other testimonials supported the deployment of The Daily Plan® into ambulatory care areas.

Involving ambulatory care areas

In the fall of 2011, patients at the Jackson Mississippi VA Medical Center who had received The Daily Plan® as inpatients, requested to receive it once they were discharged and follow-up care began at their primary care Patient-Aligned Care Teams (PACT) clinics.

This would turn out to be "just the beginning," as the request was noted on the monthly Daily Plan® national call.

Based on what had been learned on this monthly call, the Kansas City Missouri VA Medical Center Emergency Department implemented the plan – which resulted in collaboration with their primary care PACT clinics, as more and more care coordinators and providers embraced the plan.

Numerous other primary care PACT clinics have now adopted the plan, as have their community-based outpatient clinics (CBOCs). The Buffalo New York VA Healthcare System is now distributing as many as 15,000 plans per month to patients in their primary care and CBOCs.

The Daily Plan® has been added to the VA-wide PACT Toolkit number 25: "Protocol for patient/provider communication as tool type: Care Coordination."

VISN 5 is also piloting its use by sending it via secure messaging through My Health*e*Vet to select VA Telehealth patients.

Improved patient satisfaction has been a lead testimonial and the impetus supporting much of the spread of The Daily Plan®. Currently, The Daily Plan® has been implemented at *71 VA medical centers* on over 150-plus different inpatient and ambulatory areas; thirty other sites are planning implementation.

Results from facilities that have implemented The Daily Plan®

- Increased patient satisfaction survey scores
- Decreased length of stay due to vigilance over labs and imaging studies being completed in a timely manner
- Increased immunization rates
- Improved patient demographics
- Increased My Health*e*Vet enrollments

Results noting enhanced care systems

- Medication reconciliation can be achieved by pulling inpatient, outpatient, and non-VA medications into the plan
- Because the plan can be used to list appointments 30 days in advance, discharge planning can be improved because patients and families know about these future procedures and appointments and can plan for travel and days off work
- The plan can be used as a tool to assist with decreasing hospital readmissions within 30 days of discharge
- Multidisciplinary teams can use the plan to determine goals for the patient as part of discharge planning
- The Daily Plan® is not just a nursing tool, physicians can incorporate the plan into a new patient-centered concept called "bedside collaboratives."
- The plan can be rolled-out during hourly rounding
- It can be used as part of the "Clinical Nurse Leader" project

Conclusion

To "Encourage the active involvement of patients and their families in the patient's own care as a patient safety strategy" – the Joint Commission's National Patient Safety Goal 13 – is exactly what The Daily Plan® was designed to do for our Veterans – and can significantly enhance patient-centered care.

Learn more

VA employees can view two Daily Plan® videos by visiting the NCPS Intranet site.

Scroll down to these videos:

- Questions and Answers About The Daily Plan®
- The Daily Plan® Dramatized

VA employees can also find the videos within a related VeHU presentation and on a SharePoint site, as noted below.

To view the VeHU presentation:

- Go to *www.myvehucampus.com*
- If you have not yet enrolled, please do so at this point
- For those that have already enrolled, just sign in
- Go to the "on demand" section and hit the "play" button for *The Daily Plan®: Know-Ask-Participate* course

The SharePoint site

NCPS hosts a SharePoint site to provide VA employees information on The Daily Plan®.

Points of contact

We encourage you to contact us for more information: *Cheryl.Mitchell@va.gov* or *Beth.King@va.gov*